South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: _____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Carrier: _____

Preparer's Name: _____ Preparer's Phone #: ( ) _____

Date of injury: _____ Date of Notice to Employer of Injury: _____

I. Payment of Temporary Compensation

Check one: ☐ Initial period ☐ Additional period ☐ Corrected compensation rate

(choose A, B, or C)

☐ A. Temporary Total at the compensation rate of $_____ per week. For this period of disability, disability began on _____ and the date of first payment was _____.

☐ B. Temporary Partial at the compensation rate of $_____ per week. Note: When the Temporary Partial compensation rate will vary, report the first payment here. Supplement this report throughout the period of Temporary Partial compensation by filing a **Form 15S** with the **Form 18**, which shall be filed six months after the date of injury and each six months thereafter until the file is closed.
For this period of disability, disability began on _____ , and the date of first payment was _____.

Calculation of Temporary Partial Rate:

	Average weekly wage before injury	$
–	Current weekly wage	$
=	Difference in wages before injury and now	$
x	.6667	$
	Temporary Partial Compensation Rate	**$**

☐ C. Salary in lieu of Temporary ☐ Total ☐ Partial (choose one) compensation in the amount of $_____ per week.
For this period of disability, disability began on _____ and the date of first payment of salary in lieu of temporary compensation was _____.

THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF INJURY. ATTACH DOCUMENTATION AS TO THE REASON OF THE TERMINATION.

II. Termination of Temporary Compensation

Temporary compensation payments were stopped on _____ for the following reason:

☐ Claimant has returned to work at least 15 days and no temporary partial compensation is due.
☐ Claimant agrees he/she is able to return to work and has signed a **Form 17**.
☐ Based on a good faith investigation, the claim is denied. Reason for denial: _____
☐ Claimant has been released to return to work without restrictions and employment has been offered.
☐ Claimant has been released to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.
☐ Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

_____ _____
Signature of Claims Administrator Date

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:

The employer's representative may stop temporary compensation within 150 days of the date of notice of injury for the above reasons. However, if you believe that the temporary compensation should not have been stopped, you may request a hearing by signing below and returning this form to SCWCC Judicial Department at the address at the top of this form. A hearing will be held within 60 days of receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION.
I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one: **Form 15(II)** ☐ Has ☐ Has not been received.

_____ _____
Signature of Claimant or legal representative Date

Employer's representative must complete and file **Form 15** with Claims Department within ten days after compensation begins or is terminated. Employer's representative must serve the **Form 15** on the claimant when compensation begins per R.67-211. Employer's representative must prepare and serve **Form 20** within thirty days of beginning compensation per R.67-1603. Employer's representative must serve per R.67-211 two copies of the **Form 15** on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest termination of compensation by completing section III of the **Form 15** and filing it with Judicial Department.